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ABSTRACT

Drawing on lessons from six case studies, this policy paper highlights the most innovative approaches states and communities are currently using to finance preventive and early intervention services as well as more traditional treatment services for young children's mental health. The case studies are based on interviews with policy and program leaders in Florida, Indiana, Ohio, and Vermont, as well as the metropolitan areas of San Francisco and Cuyahoga County (Cleveland), Ohio. The policy brief is presented in five sections. Section 1 of the policy paper provides a "snapshot" of each of the sites as a context for the more specific discussion of funding streams and funding strategies. Section 2 describes the major federal funding streams that are being used to finance early childhood mental health services, highlighting the role of state and private funds. For each funding stream, there is a description of the program, its implications for early childhood mental health, and how the case study sites have or have not used it. Section 3 explores the funding strategies in depth, focusing on the funding mechanisms that states are using to maximize the impact of fiscal resources, as well as the related planning, collaborative, and administrative structures that are emerging to maintain early childhood mental health initiatives. Also discussed are the common challenges that sites have encountered and efforts to address these challenges creatively. Section 4 summarizes the lessons and explores implications for others seeking to develop similar services. Two appendices list key contacts for each site and selected references and resources. (Contains 16 endnotes.) (KB)

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Promoting the Emotional Well-Being of Children and Families

POLICY PAPER #4

ED 467 051

Making Dollars Follow Sense

Financing Early Childhood Mental Health Services to Promote Healthy Social and Emotional Development in Young Children

PS 030520

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PROMOTING THE EMOTIONAL WELL-BEING OF CHILDREN AND FAMILIES

This document is part of a policy paper publication series that reflects a larger effort the National Center for Children in Poverty (NCCP) is undertaking with generous support from the Casey Family Programs to help the most vulnerable families. It continues and builds on NCCP's earlier work to document effective strategies and highlight policy opportunities and challenges to promote the emotional health of young children and families. The policy papers in this series will help policymakers, community leaders, and advocates take action to ensure the healthy development of children and their families.

This policy paper highlights the most innovative approaches states and communities are currently using to finance preventive and early intervention services as well as more traditional treatment services for young children's mental health. It also explores what else might be done to mix, match, and leverage all available resources for early childhood mental health needs. It includes descriptions of the study sites and major federal funding streams; the role of state and private funds; possible funding combinations and related planning, collaborative, and administrative structures to sustain initiatives; and common challenges and possible solutions for developing early childhood mental health services.

PROMOTING THE EMOTIONAL WELL-BEING OF CHILDREN AND FAMILIES

Making Dollars Follow Sense

Financing Early Childhood Mental Health Services to Promote Healthy Social and Emotional Development in Young Children

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Making Dollars Follow Sense: Financing Early Childhood Mental Health Services to Promote Healthy Social and Emotional Development in Young Children

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Executive Summary

Drawing on lessons from six case studies, this policy paper highlights the most innovative approaches states and communities are currently using to finance early childhood mental health services and explores what else might be done to mix, match, and leverage all available resources. The focus is on prevention and early intervention services to not only help children directly, but equally important, to help their families and other caregivers address the social and emotional challenges children face. The case studies are based on interviews with policy and program leaders in the states of Florida, Indiana, Ohio, and Vermont, as well as two metropolitan areas—San Francisco and Cuyahoga County, Ohio (where Cleveland is located).

"Policies and programs aimed at improving the life chances of young children come in many varieties... They all share a belief that early childhood development is susceptible to environmental influences and that wise public investments in young children can increase the odds of favorable developmental outcomes."

National Research Council and Institute of Medicine, Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education; Shonkoff, J. P. & Phillips, D. (Eds.). (2001). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press., p. 10

Snapshots of the Sites

Florida

Early childhood mental health efforts in Florida have included: developing a state strategic plan to provide supportive services to all young children, children facing special risks, and children needing more intensive treatment; addressing some of the most vexing Medicaid-linked barriers to funding; and piloting treatment programs for more vulnerable infants and their families.

Indiana

Efforts to address issues of social and emotional development and mental health in young children in Indiana have been embedded in a broader effort to enhance early intervention services (Part C) for all at-risk young children. In that context, mental health-related initiatives have focused specifically on prevention and early intervention services designed to improve professional training and increase referrals. Funding has involved diversifying, maximizing, and blending multiple funding streams.

Ohio

The early childhood mental health efforts in Ohio have used targeted state general fund dollars to create a statewide grant program to promote early childhood mental health consultation, primarily addressing prevention and early intervention. Local activities are mainly led by community mental health boards and involve an array of child-serving agencies.

Vermont

The early childhood mental health efforts in Vermont involve the expansion of both direct treatment and consultation, encompassing prevention, early intervention, and treatment services. Using a federal children's services mental health grant as the entry point to create the Children's UPstream Project (CUPS), a comprehensive early childhood mental health initiative, the state has developed a strategic approach to maximizing the impact of its federal grant dollars utilizing Medicaid and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) funds and state child care match dollars.

Cuyahoga County, Ohio

Early childhood mental health efforts in Cuyahoga County have been embedded in a larger early childhood initiative. Supplementing the existing capacity to provide more intensive treatment to young children and their parents, the county has expanded its prevention and early intervention services by integrating consultation into existing early childhood programs. Pilot efforts to improve Medicaid reimbursement strategies and diagnostic categories are underway. The county has used significant local public and private dollars, as well as state and federal funding streams.

San Francisco, California

Early childhood mental health efforts in San Francisco have been built on existing collaboration, spurred by flexible funding from TANF welfare reform. The city has created a network of early childhood mental health consultants responsive to different ethnic needs, primarily providing prevention and early intervention services. The initiative uses a pooled funding strategy that involves multiple agencies and federal, state, and local funding streams.

Lessons from the Sites

- Sites are using broad early childhood initiatives as a platform from which to launch early childhood mental health services. Leadership comes from many different agencies and individuals, and the scope of the effort varies considerably across the sites. For example, the focus may be on one age group (e.g., infants and toddlers) or one service (e.g. , early childhood mental health consultation). Only one site has developed and implemented a comprehensive system of care fully integrated into the early childhood community.

- Because of the initiatives, young children, their families, and their caregivers have access to resources and services that simply did not exist before. Across the sites, investments have increased by about $12 million.

- Although most sites are emphasizing early childhood mental health consultation, a broad range of services are being funded (including training for early childhood staff in mental health issues, parent-to-parent support groups, and behavioral aides in the classroom).

- Funding strategies vary in complexity across the sites. In most there has been a heavy reliance on federal dollars. But in some sites, state dollars provide the only major funding stream. In others, there has been a deliberate effort to draw funds from multiple sources, including entitlement dollars, and state and local public funds, as well as private dollars and special grants.

"Its about leadership, about not saying no or that you can't do something because of rules and money. We need to say yes, to solve problems and make kids safer and healthier."

James Hmurovich, Director, Family and Children Division, Family and Social Services Administration, Indiana

- Major federal funding sources include Medicaid/EPSDT, the Child Care and Development Fund, TANF, the Children's Mental Health Services Program, and the Part C Early Intervention Program of the IDEA.

- State Medicaid agencies in several sites have developed new policies to maximize the use of Medicaid funds for mental health services to young children, but no site has taken full advantage of what is possible. Other federal programs have played a supporting role in some, but not all of the sites. For example, Part C has been central in Indiana, TANF in San Francisco.

- The sites are using four major strategies to maximize funding: blending funds, braiding funds, maximizing Medicaid, and using state funds strategically to match federal dollars and to pay for support services—such as staff and parent training—that cannot otherwise be supported.

- Common fiscal challenges include the difficulty of providing preventive and early intervention services without requiring a diagnosis, using all available funds, and sustaining funding, particularly given the worsening larger economic context.

- Interagency and public-private collaboration are essential to developing and financing a system of care that provides a continuum of early childhood mental health services. Collaboration, once set in motion, works best where sustained by formal mechanisms. Financial arrangements frequently are supported by legislation, regulation, memoranda of understanding, and other formal guidance.

Ten Action Steps for States and Communities

Building on the lessons of these pioneering sites, below are action steps that other communities and states can take to strengthen their attention to the social, emotional, and behavioral needs of young children.

1. Start small. Apply for small grants or turn to local foundations to jump-start a community- or state-level planning process, building on other collaborations on behalf of young children.

2. Test out new service approaches to make sure they fit with the community. Consider evidence-based practice, where there is an evidence base, and lessons from prior efforts.

3. Develop cross-training initiatives to build a shared understanding of what early childhood mental health services are, how they are related to other shared goals, such as promoting school readiness, and how they might be funded.

4. Build or strengthen collaborative relationships to develop a systematic funding strategy that will support the development of preventive and early intervention services. For example, use child care improvement funds for mental health consultation; establish or use existing formal mechanisms at the cabinet, state agency, or local agency level; make sure parents are involved.

5. Analyze existing levels of funding for early childhood mental health. How do the funds flow to reach local service providers and meet family needs? Are funds being used for the right services? Are the funds sufficient? Do services address the needs of infants and toddlers as well as preschoolers?

6. Assess the funding streams that could be used and what barriers they pose: for example, does the state Medicaid agency pay for all covered services, including child and family therapy?

7. Develop a targeted strategy to maximize the impact of Medicaid/EPSDT. For example, include age-appropriate developmental, emotional, and behavioral measures in the recommended EPSDT screening protocol; make sure that reimbursed services are appropriately defined for young children; make sure that parent-child therapies are covered.

8. Consider redesigning reimbursement and billing practices to maximize the use of all available dollars, exploring some of the strategies used by the sites described in this report such as blended or braided funds.

9. Develop a method to gather the kind of outcome data needed to refine and sustain funding for early childhood mental health strategies.

10. Promote the development of targeted federal funding as a catalyst for the development of early childhood mental health services.

Introduction

A recent and compelling synthesis of developmental knowledge and neuroscience highlights the importance of a child's earliest emotional development and relationships. A report from the Institute of Medicine/National Research Council, *From Neurons to Neighborhoods: The Science of Early Childhood Development*,[1] suggests that for some children, emotional and behavioral problems serve as a kind of red flag. Without help, these young children have a higher probability of experiencing problems in infancy and toddlerhood and during the preschool years, and in making a successful transition to school. In response, states and communities are increasingly planning and implementing early childhood mental health service strategies to respond to the needs of these children, their families, and their other caregivers (e.g., child care providers, home visitors, Head Start, Early Head Start, and prekindergarten teachers). But too often, these efforts are hampered by difficulties in designing sustainable funding strategies.

Drawing on lessons from six case studies, this policy paper highlights the most innovative approaches states and communities are currently using to finance not just more traditional treatment services for young children, but also preventive and early intervention services. It also explores what else might be done to mix, match, and leverage all available resources. These case studies are based on interviews with policy and program leaders in the states of Florida, Indiana, Ohio, and Vermont, as well as two metropolitan areas—San Francisco and Cuyahoga County, Ohio (where Cleveland is located).

This policy paper is one of a series developed by the National Center for Children in Poverty entitled *Promoting the Emotional Well-Being of Children and Families*. It is organized in four sections. The first section provides a "snapshot" of each of the sites as a context for the more specific discussion of funding streams and funding strategies. Collectively, these descriptions shed light on the nature of the early childhood mental health services that are being funded. The second section describes the major federal funding streams that are being used to finance early childhood mental health services (as well as some that have not been used, but might be). It also highlights the role of state and private funds. For each funding stream, there is a brief description of the program, of its implications for early childhood mental health, and of how the case study sites have (or have not) used it.

"If dollars don't follow sense, we will be faced with the same repetitive problems—a slow moving wave of kids coming through with preventable problems."

Billie Navojosky, Director, Positive Education Program,
Early Intervention Center West, Cleveland, Ohio

The third section explores the funding strategies in depth, focusing on the funding mechanisms that states are using to maximize the impact of fiscal resources, as well as the related planning, collaborative, and administrative structures that are emerging to sustain early childhood mental health initiatives. The section concludes with a discussion of the common challenges the sites have encountered and their efforts to address these challenges creatively. The final section summarizes the lessons and explores the implications for others seeking to develop early childhood mental health services. Fuller descriptions of the sites are available on the Web sites of the National Center for Children in Poverty (www.nccp.org) and the Georgetown University Center for Child and Human Development (gucdc.georgetown.edu).

How the Information Was Gathered

The information in this policy paper was developed using a case study method. Case studies aim to illuminate a question or decision by looking at the subject in rich detail: in this instance, to investigate early childhood mental health financing within its real-life context.[2] Six sites were selected, each with illustrative early childhood mental health activities underway. These states and communities are among those previously identified and described through the work of the National Center for Children in Poverty and the Georgetown University Child Development Center. This group of six was chosen to represent a range of possible state and local approaches.

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Interviews were conducted with 122 state government officials, local program staff, and other providers, parents, and advocates between April and October 2000. Approximately 20 individuals were interviewed in each location, based on their experience with the initiative or their role in a related government or service agency. The initial contacts were identified from previously published program descriptions. Additional individuals were identified by key informants using an expanding circle technique.[3] All the interviews involved semi-structured, face-to-face interviews using open-ended questions that permit the participants to determine the direction of the response and to provide their own knowledge, attitudes, and opinions.[4] A pretest of the interview instrument and related tools was conducted in April 2000. Tapes and notes of interviews, along with documents describing programs and policies, were used to develop the profiles.

A Note on Terminology

Some initiatives use the terms infant and toddler mental health, others early childhood mental health. In most instances, both terms refer to the development of services and strategies to support young children from birth through age five, although in a few sites, the focus is on infants and toddlers or preschoolers. The term infant and toddler or early childhood mental health services refers to "strategies and service delivery mechanisms to help families and other caregivers gain access to information, mentoring, support, early intervention, and, if needed, treatment to prevent further damage and reverse early harms related to problematic social, emotional, and behavioral development. Sometimes, these strategies involve the child directly. But often, because of their age, the best way to help young children is to help their caregivers—family members, child care providers, home visitors, and teachers—to be more effective."[5]

SECTION 1:
Snapshots of the Study Sites

As a context for the more detailed discussion of funding streams and strategies, this section provides a brief snapshot, in alphabetical order, of each of six study sites—four state and two local. The point-in-time snapshots highlight the key components of the early childhood mental health efforts: the types of services that are being developed, the core funding strategies, and the major challenges.

To provide some commonality, the service approach is summarized using the framework that was developed in Florida. That framework calls for three levels of infant mental health/early childhood mental health services. (See Florida's Strategic Plan for Infant Mental Health at: www.cpeip.fsu.edu.)

- Level I services are preventive strategies intended to strengthen caregiver/child relationships for all children. This includes, for example, mental health consultants who work in child care settings or serve as consultants to home visiting workers, or even a support/supervision group for child care providers.

- Level II services are early intervention strategies targeted to children at risk of poor developmental outcomes, including social and emotional outcomes. This includes, for example, mental health consultants in child care settings who develop specific strategies to help a child in a family affected by domestic violence or substance abuse, or a behavioral aide placed in a child care setting to help a child whose behavior is very disruptive.

- Level III services involve specialized treatment for those young children and families who need intensive help. It includes, for example, dyadic, mother-baby therapy for a child who has been abused or neglected, or wraparound services that support both the mother and child for a young child with a diagnosed serious emotional and behavioral disorder.

RECOMMENDATIONS REGARDING CHILDREN'S SERVICES

From Changing Lives: Ohio's Action Agenda for Mental Health
(released January 2001 by the Ohio Commission on Mental Health)

- The Department of Mental Health and the mental health community should determine an appropriate balance between treating children and youth with the most severe mental illnesses and providing prevention and early intervention services.
- The Department of Mental Health should work with all shareholders to improve access to mental health services delivered where children spend most of their time. This strategy must include true shared funding of prevention and early intervention services.

"We didn't want to simply train mental health specialists but rather to infuse the concepts and competencies across the board into early childhood care, education, and intervention."

Maureen Greer, former assistant deputy director, Bureau of Child Development and Part C coordinator, Indianapolis, Indiana

Florida

The early childhood mental health efforts in Florida have focused on creating a broad state vision and plan for implementation, addressing some of the most vexing Medicaid-linked barriers to funding and seeding Level III treatment strategies for more vulnerable infants and their families.

Efforts to enhance the healthy social and emotional development of young children in Florida have been spearheaded by a group of strong and effective advocates with support from key officials in state agencies. They have:

- Developed and widely disseminated *Florida's Strategic Plan For Infant Mental Health* that was based on the work of a broad coalition of advocates, government officials, and service providers and was supported with both public and private dollars.
- Revised state Medicaid guidelines to encourage the use of more appropriate assessment tools for young children and to provide reimbursements to a broader range of providers.
- Gained legislative support for three pilot infant mental health demonstration projects based in a Child Development Center, a Community Mental Health Center, and a Circuit Juvenile Court, the last of which has also developed an Early Head Start program for infants and toddlers involved in dependency proceedings.

In addition, the Center for Prevention and Early Intervention at Florida State University has designed and tested a relationship-based training program for the state's network of Part C early interventionists. (The FSU Center has also developed and provided Level I training for home visitors and child care providers. They also received funding from a private foundation and a children's services council to do a year-long training program in order to increase Level III work force capacity that will train 30 infant/early childhood mental health therapists starting in September 2002.) Miami has also been the site of a Starting Early Starting Smart grant funded through the Substance Abuse Mental Health Services Administration and a private foundation, the Casey Family Programs (now the Marguerite Casey Foundation).

The efforts to raise visibility of the need for infant and toddler mental health services has won support from the legislature and some state leaders. Given a growing budget crisis, however, there is concern about the extent to which the effort can be sustained and expanded.

Indiana

In Indiana, efforts to address issues of social and emotional development and mental health in young children have been embedded in a broader effort to enhance early intervention services for all at-risk young children. Mental health-related initiatives have focused specifically on Level I and II services designed to improve professional training and increase referrals. Funding has involved diversifying, maximizing, and blending multiple funding streams.

To promote more attention to early childhood mental health issues within the wider effort to improve the delivery of early intervention services to young children, Indiana has:

- Developed a broad state fiscal strategy with a centralized billing mechanism to maximize the impact of available state and federal resources for early intervention, including early mental health services, by blending existing funds from a variety of sources supported at high levels of state government.

- Invested in training and mentoring strategies to promote professional and parental awareness about infant and toddler mental health as part of a broader effort to address the special health care needs of young children with funding from a federal Title V Maternal and Child Health grant. The training system, while based in the state Part C early intervention program, often includes developmental specialists, social services agency staff, early intervention providers, child care staff, and child health staff from health departments at the local level. Parents also are included in these efforts.

- Created a statewide infant mental health development team to oversee the training of providers based on a set of core competencies in infant mental health, set up mentoring teams across the state, and established an infant mental health association.

By maximizing funds and streamlining the enrollment process, an enhanced continuum of care for children from birth to three years of age became possible, and existing dollars reached more children. In this process, the state has taken deliberate steps to identify and serve infants and toddlers with social-emotional risks and delays. As a result of interagency collaboration, program promotion, provider training, and single-point-of-entry mechanisms, referrals to the early intervention system increased threefold from 1996 to 2000, with 13 times the number of referrals from mental health agencies. In addition, through the network of Hoosier Assurance Plan contracts, the state's mental health program providers are annually serving nearly 2,500 children under age six in families with incomes up to 200 percent of the poverty level.

Ohio

The early childhood mental health efforts in Ohio have used targeted state general fund dollars to create a statewide grant program to promote early childhood mental health consultation, primarily involving Level I and II services. Local activities are primarily led by community mental health boards and involve an array of child-serving agencies.

In an effort to promote greater attention to early childhood mental health, the Ohio Department of Mental Health (ODMH):

- Created the Early Childhood Mental Health Initiative, a $2.6 million state grant program for local agencies (primarily local community mental health boards) to build statewide capacity within the mental health and early childhood care and education systems to promote the healthy social and emotional development of young children.

Grant funds could be used for: (1) mental health consultation to center- and home-based early childhood programs, (2) training for early childhood staff in mental health issues, (3) cross-system training for mental health and early childhood professionals and parents, (4) creation of parent-to-parent family support groups, (5) work with families to enhance caregiver skills, and (6) public awareness activities.

In fiscal year 2001, as a result of Ohio's Early Childhood Mental Health Initiative, 63 mental health consultants provided services to over 7,000 children and nearly 500 child care, Head Start, Early Head Start, and home visiting programs statewide. At the local level, the grant program has led to greater collaboration with the state's home visiting and early intervention programs in some communities.

However, despite a recent Ohio Commission on Mental Health report urging more attention to prevention and early intervention for children, (see box on page 8) using Medicaid in addition to state funds for prevention and early intervention remains very difficult. This is so because current interpretations of medical necessity and individualized service plan requirements are not appropriate for young children. Significant budget concerns may also limit continuing efforts.

Vermont

The early childhood mental health efforts in Vermont involve the expansion of both direct treatment and consultation, encompassing Level I, II, and III services. Using a federal children's services mental health grant as the entry point, the state has worked to develop a strategic approach to funding by maximizing the impact of federal dollars, especially Medicaid and Early and Periodic Screening, Diagnosis, and Treatment (ESPDT) funds, and using state match dollars strategically.

Vermont has developed the most comprehensive effort in the country to infuse early childhood mental health services into the early childhood community, using a six-year, $5.7 million federal grant from the Center for Mental Health Services of the federal Substance Abuse Mental Health and Services Administration (SAMHSA). The aim of the grant has been to stimulate local activities targeted to prevent serious emotional and behavioral disorders. Vermont has:

- Created the Children's UPstream Project (CUPS) to develop statewide prevention, early intervention, and treatment strategies for young children, their families, and their caregivers. (See box.)
- Integrated the effort to promote early childhood mental health services into the ongoing efforts to enhance other early childhood programs that are led by the State Early Childhood Work Group, which includes interagency state staff as well as parents, providers, and advocates.
- Implemented a local planning process for communities to decide how best to allocate the CUPS funding that they received in order to effectively meet local needs.
- Developed a strategic funding approach that involves maximizing the use of Medicaid/EPSDT as well as the strategic use of state dollars as match monies for these and other federal programs. Vermont targeted state funds for prevention as its contribution to the federal SAMHSA grant.

Using these combined strategies, Vermont has created new staff positions for 26 CUPS workers across the state and expanded both behavioral health consultation and treatment capacity. During the first three years of CUPS, more than 1,000 children and families received respite, crisis outreach, home-based services, case management, or other direct services, and more than 1,000 additional consultations—reaching over 4,000 people—were provided to early care and education agencies.

CORE GOALS FOR VERMONT'S CUPS

- Support and preserve families of young children experiencing or at risk for experiencing severe emotional disturbance through access to behavioral health and other community-based services designed to meet their individual needs and build on their strengths.
- Strengthen the behavioral health of families with young children.
- Decrease the incidence of children entering kindergarten lacking emotional and social skills needed to succeed.

Notwithstanding this success, the state faces a challenge once the grant has ended in financing preventive and supportive services that are not reimbursable under Medicaid. These include training, parent-support services, resource and referral services, volunteer coordination, and public awareness.

Cuyahoga County, Ohio

The early childhood mental health efforts in Cuyahoga County have been embedded in a larger early childhood initiative. Supplementing the existing Level III services, the county has expanded its capacity to provide Level I and II services, integrating consultation into existing early childhood programs. The county has used significant local as well as state and federal funding streams.

The Cuyahoga County effort to promote more attention to early childhood mental health issues is part of the larger countywide Early Childhood Initiative, which is a public-private partnership designed to improve, expand, and better coordinate child care quality efforts, home visiting, health coverage outreach, and special-needs child care. To meet early childhood mental health needs, the leaders have:

- Established Day Care Plus, an early childhood mental health consultation program that grew out of a partnership among the Cuyahoga County Board of Mental Health, Starting Points, the local child care resource and referral agency, and the Early Intervention Centers of the Positive Education Program (PEP) that serves seriously behaviorally and emotionally challenged young children and families.

- Crafted, with funding from the state Early Childhood Mental Health Initiative and local funds, a three-agency Early Childhood Mental Health Pilot Project for the purpose of demonstrating improved outcomes using best practices.

- Linked Cuyahoga County's early childhood mental health project to other service systems to strengthen the local Early Childhood Initiative and to provide consultation in early intervention centers and home visiting programs, as well as child care centers and child care resource and referral agencies.

- Used the Early Childhood Mental Health Pilot Project of PEP's Early Intervention Centers to test strategies to reduce administrative barriers to financing early childhood mental health services through Medicaid. The aim is to eliminate the use of inappropriate assessment tools and conflicting mental health and special-education planning requirements. The other two agencies participating in the pilot project are testing new diagnostic tools for Medicaid reimbursement.

The Early Childhood Initiative, into which the mental health strategies are infused, has ambitious goals: to reach 50,000 parents each year with information on parenting skills and community resources; to provide 8,000 "Welcome Home" visits to babies born to first-time and teen mothers; to provide 4,000 higher-risk families with home visiting through Early Start; to increase the percentage of eligible children enrolled in Medicaid and the State Children's Health Insurance Program (SCHIP); to provide certified child care for 4,000 additional children each year; and to offer enhanced child care to 500 children with special health care needs, including those facing social and emotional challenges.

Through Day Care Plus, 83 center-based and family child care providers have received services and support, 259 children at risk for removal were maintained in their child care settings, over 300 training sessions were held for parents, and over 1,500 child care staff participated in training.

As a result of the focus on early childhood mental health, the County Community Mental Health Board has recognized the need to improve mental health services to infants and toddlers as well as to provide prevention and early intervention services. The county is also hopeful that its efforts to address administrative barriers will provide the needed impetus for the state to use Medicaid more effectively to benefit young children in need of mental health services across Ohio.

San Francisco, California

The early childhood mental health efforts in San Francisco were spurred by welfare reform. The city has created a network of early childhood mental health consultants responsive to different ethnic needs, primarily providing Level I and II services. The initiative uses a pooled funding strategy that involves multiple agencies and funding streams.

The San Francisco efforts to increase the focus on early childhood mental health issues grew out of the planning and coordination strategies developed by the San Francisco Starting Points Early Childhood Interagency Council and the San Francisco Children and Families Commission (part of a statewide initiative known as Prop 10), as well as child care planning bodies. San Francisco has:

- Identified, through a planning process initially spearheaded by the Starting Points Early Childhood Interagency Council and subsequently the Proposition 10 Children and Families Commission, the critical need for early childhood mental health consultation and services as part of its efforts to help families successfully transition from welfare to work.

- Established a network of ethnically diverse early childhood mental health consultants who are reaching a majority of child care centers, building relationships with family day care providers, supporting

the mental health components of Head Start centers, and strengthening the child care components of homeless and domestic violence shelters.

- Used $700,000 of $2 million allocated by the San Francisco Board of Supervisors for a High Quality Child Care Initiative to provide mental health support and consultation to child care providers working to help families transition successfully from welfare to work.

- Enhanced funding for the mental health consultation program by creating an administrative strategy to identify appropriate funding streams for different services, using pooled funds from multiple sources (e.g., general revenue, Medicaid, city funds, and Temporary Assistance for Needy Families (TANF) monies transferred to child care) pursuant to memoranda of understanding among the agencies responsible for the funds.

- Established a framework for reimbursement of consultation services through the administering agency, the Department of Public Health, Community Mental Health Services - Children, Youth, and Family Section.

Reimbursed services include: (1) program consultation to enhance the quality of the program through work with child care program staff, (2) case consultation to address concerns about individual children exhibiting developmental or emotional difficulties, (3) direct therapy such as therapeutic play groups to help children learn acceptable ways to express themselves and interact with others, and (4) support groups for parents and providers.

In calendar year 2000, more than 70 child care centers and approximately 100 family day care homes received mental health consultation services. This group includes more than two-thirds of subsidized child care centers across San Francisco, with higher penetration in some neighborhoods. More than 70 percent of Head Start and Early Head Start centers were receiving mental health consultation. Nearly 4,000 children in approximately 2,000 families were served throughout the city. Efforts are underway to expand services to young children in shelters for homeless families. San Francisco is also the site of a Starting Early Starting Smart demonstration program, although to date its program has not been integrated with the larger effort described here.

"In terms of early childhood mental health and emotional wellness, what [San Francisco] did differently was link to the notion of quality in child care. This conceptual linkage opened up additional resources. For early childhood education and care initiatives, we have always looked broadly. In this case, as in others, we did the documentation of need and from that built a strategy."

Deborah Alvarez-Rodriguez, former director of the San Francisco Department of Children, Youth, and Their Families (DCYF)

However, financing treatment services is an ongoing challenge. Financing treatment for parent/child pairs or for children without a mental illness diagnosis is especially difficult under Medicaid. For children in Healthy Families (the name for SCHIP in California), the mental health benefits are limited and not well structured to fit with early childhood developmental needs. For the remaining uninsured children, many of whom are U.S. citizens with immigrant parents, the challenge is even greater. As at the other sites, there is grave concern about the ability to sustain the efforts, particularly if the state cuts flexible TANF money.

Moreover, California currently faces a budget crisis that threatens many social programs. At the time of the initial allocations, San Francisco was drawing down funds from the state reserve. In the last fiscal year, supplemental appropriations were needed to meet the baseline budget. Contingency planning is now underway to explore options in the event that the state cuts flexible funding or TANF child care funding ends.

Lessons from the Sites

Together, these snapshots paint a picture of the status of early childhood mental health developments across the country. Five points seem noteworthy.

- The scope of the early childhood mental health initiatives varies considerably: from a beginning focus on infant and toddlers in one site, to a comprehensive system of care fully integrated into the early childhood community in another. Two sites have carefully designed early childhood consultation programs. Two sites are focusing primarily on infants and toddlers, although their vision encompasses all young children, including preschoolers.

- It is clear that in these jurisdictions, young children, their families, and their caregivers have access to services that simply did not exist before. Although most sites are emphasizing early childhood mental health consultation, a broad range of services are being funded, including training for early childhood staff in mental health issues as well as training for mental health providers, parent-to-parent support groups as well as support groups for caregivers, and, in some sites, more specialized services, including dyadic therapy, wraparound services, respite and crisis care, and the use of behavioral aides in child care settings. (See box.) However, with the exception of Vermont, not all of these services are being financed for young children and at a specific site.

- The sites illustrate how early childhood and mental health professionals have worked with public officials to augment the services of child care centers, Head Start programs, family resource centers, home visiting programs, child development centers serving children with physical disabilities, early intervention programs, medical settings, homeless and domestic violence shelters, and the justice system. In sum, they have brought services to the settings in which children spend their days and where high-risk families receive support.

- Funding strategies vary in complexity across the sites. In some sites, such as Ohio, state dollars provide the only major funding stream. In contrast, in Indiana, there has been a deliberate effort to draw funds from multiple sources, with a heavy reliance upon federal dollars, and in Vermont, maximizing federal-state matching has been a high priority.

- State investments of both federal dollars and state dollars along with local and private dollars have resulted in new investments in early childhood mental health. For example, this has included: $2.3 million in state funds over three years to the Early Childhood Mental Health Initiative in Ohio; more than $1.2 million local public/private funds for the Early Childhood Mental Health pilot in Cuyahoga County; $5.7 million federal plus state match over six years for Children's UPstream Services in Vermont; more than $2 million TANF, local, and other dollars for Child Care Mental Health Consultation in San Francisco; and more than $1 million in state general revenue funds for three Florida Infant Mental Health pilot projects. However, given the rapidly declining economic context, most of the sites are worried about whether they will be able to sustain and grow the gains that they have made in addressing a very pressing issue for the larger early childhood agenda.

EARLY CHILDHOOD MENTAL HEALTH SERVICES FUNDED BY THE STUDY SITES

- Screening and assessment for emotional-behavioral concerns.
- Enhanced screening and assessment through placement of social workers in pediatric care settings.
- Early childhood mental health consultation for individual children.
- Early childhood mental health consultation and training for early childhood program staff.
- Relationship-based, parent-child therapy for families at risk as well as families who have entered the child welfare system.
- Specialized (day) treatment in a variety of early childhood settings.
- Care coordination and case management for children entering the child welfare services system, particularly those entering foster care.
- Wraparound treatment for young children with serious emotional disturbances.

SECTION 2:

An Overview of the Major Funding Sources for Early Childhood Mental Health Services

This section explores the major funding sources to support early childhood mental health initiatives, focusing mainly on federal programs and funding streams. These have been the primary working tools in the development of early childhood mental health strategies, typically supplemented with state, local, and private funds. This section provides a brief overview of the funding sources, highlights their implications for early childhood mental health, and indicates the extent to which the sites have actually made use of these different funding streams.

Health Programs

Medicaid and EPSDT

Medicaid is the largest and most important public source of health care financing for children. It is a federal-state entitlement program that provides health care for one in four poor children. All children younger than six with family incomes up to 133 percent of the federal poverty level ($17,650 annual income for a family of four in 2001) are eligible. At their option, state eligibility levels may be higher. In the study sites, when combined with SCHIP (see below) Medicaid eligibility levels vary from 200 percent to 250 percent of the poverty level. States have considerable flexibility in designing their Medicaid programs for children as long as they meet certain basic requirements, but they must match their Medicaid dollars with nonfederal dollars.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is the child health benefit package of Medicaid that mandates states to cover a full range of preventive, diagnostic, and treatment services for all Medicaid beneficiaries under age 21. EPSDT benefits are based on a broad standard: a service is medically necessary if needed for the "early" diagnosis and treatment of a condition.

Because the purpose of EPSDT is prevention, the medical necessity standard for children in Medicaid must take into account not only whether a service will cure or restore health, but also whether it may prevent the onset of a physical or mental condition or ameliorate a condition. The EPSDT pediatric medical necessity definition is thus more inclusive than the definitions used in standard commercial insurance. However, confusion about the scope of covered services is widespread, and the definition of medical necessity under EPSDT is widely misinterpreted. Thus, although federal EPSDT law requires that all child Medicaid beneficiaries have access to any covered service when medically necessary, states must adopt guidelines, benefit definitions, eligibility processes, and payment mechanisms in order to effectively carry out this entitlement. Few states have created such mechanisms in a systematic fashion.

Implications for Early Childhood Mental Health

Medicaid is a critical source of financing for mental and behavioral health assessment, therapies, and wrap-around services for children. However, to date, Medicaid mental health services have largely been designed for older children and adolescents. As a result, reimbursable services and assessment tools are often not defined in ways that are appropriate for young children and their families. For example, some states do not reimburse for infant-toddler therapies; others do not include prevention or early intervention services, but serve only children with a diagnosis of SED (serious emotional disturbance). Under EPSDT, there are opportunities to provide more preventive and early intervention services. Here too, however, states have not taken advantage of the possibilities.

View from the Sites

Although most of the sites are working to make Medicaid/EPSDT better fit children's needs, Vermont and Florida have been especially innovative in crafting more appropriate administrative rules and in using state match money strategically for early childhood mental health services. Cuyahoga County is piloting strategies that could be adopted by the state of Ohio. Even so, no site has fully maximized the possibilities through both Medicaid and EPSDT.

OPPORTUNITIES FOR EARLY CHILDHOOD MENTAL HEALTH IN STATE IMPLEMENTATION OF MEDICAID AND EPSDT

- Use Medicaid financing for covered services given to children in child care settings, Head Start, and other settings that provide early childhood care and education.
- Track the results of developmental screening and assessment under EPSDT that might identify opportunities to intervene and support the healthy emotional development of young children showing problems.
- Eliminate treatment barriers that require a mental or behavioral health diagnosis for young children.
- Finance intervention services for children at high risk for emotional problems, such as those who have witnessed domestic violence or have a parent with documented substance abuse or depression.
- Establish billing codes and approve payments for family therapy that includes parents and children together and is focused on strengthening their relationships.
- Use EPSDT case management to improve care coordination, particularly for children entering foster care or other child welfare arrangements.
- Specify early childhood mental health responsibilities under Medicaid managed-care contracts.
- Permit early childhood "preventive mental health" services to be delivered outside of mental health centers by other providers.

State Children's Health Insurance Program—SCHIP

All states have used the federal option to create a State Children's Health Insurance Program. States may use Medicaid, a separate insurance plan, or a combination of the two. Under a Medicaid (M-SCHIP) plan, all of the Medicaid policies and benefits described above apply to covered children. Under separate state plans, mental health coverage may be limited, and all separate (S-SCHIP) plans have more limited benefits than federal Medicaid-EPSDT requirements.

Implications for Early Childhood Mental Health

While some states have designed SCHIP benefit packages that provide reasonable mental health coverage, none of the study sites (and no others that we are aware of) have developed special provisions for early childhood mental health.

View from the Sites

No state in this study reported specific efforts to use the SCHIP plan to finance early childhood mental health. However, Vermont uses the Medicaid benefit plan and the EPSDT pediatric medical necessity standard for SCHIP. This means that children with family income up to 300 percent of poverty can benefit from the early childhood mental health services funded through these mechanisms.

Title V Maternal and Child Health (MCH) Services Block Grant

The Title V MCH Services Block Grant provides flexible funding to states (matched at one dollar for every three federal dollars) to enable states to plan, promote, provide, coordinate, and evaluate health care for pregnant women, mothers, infants, children, and adolescents. It also provides grants for special projects. A portion of MCH Block Grant funds are dedicated to serving children with special health care needs. Funding is limited and is often used to fill gaps, assure access, or affect systems change. Many states provide financing only for selected services such as those not covered by Medicaid or for children who are uninsured.

Title V Programs for Children with Special Health Care Needs. The Title V MCH Block Grant program includes an emphasis on children with special health care needs. This group has been defined in federal guidance as: "Children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally."[6]

Title V SPRANS Grants. Title V also sets aside federal dollars to carry out an array of demonstration and other special projects. The oldest set aside is for Special Projects of Regional and National Significance (SPRANS) in maternal and child health.

Implications for Early Childhood Mental Health

State laws, regulations, and program guidance determine who qualifies as a child with special health care needs, who will receive services, and what services will be financed. Although they could, most states do not

EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

Early childhood mental health consultation is a way to promote emotional well-being and provide needed interventions, beginning where most young children spend their days. Consultation is a "two-for-one" strategy; early childhood mental health consultants can both intervene with individual children and families and improve the quality of early childhood care and education programs. Mental health consultation is being used by each of the case study sites and, through these programs and initiatives, reaches child care centers, family day care homes, Head Start centers, family resource/support programs, shelters, and other settings. Different funding streams are being used, including mental health, child care, TANF, and Medicaid funding

"The issue that kept coming up [in the Early Childhood Steering Committee meetings] was an unmet need, not so much mental health services for kids, but for mental health consultation for those who work with young children."

Cheryl Mitchell, Deputy Secretary in the Agency for Human Services, Vermont

currently include mental and behavioral health conditions in the state-determined definition of children with special needs who qualify for services or supports.

View from the Sites

Using a SPRANS grant, Indiana has promoted and enhanced "Integrated Services for Children with Special Health Care Needs" to strengthen the state's focus on infant and toddler mental health as well as several other strategies on behalf of children with special health care needs. In Indiana, San Francisco, and Vermont, Title V state block grant dollars have been blended with other funds to finance early childhood mental health projects, and special project grants have been used to pilot innovative efforts.

Early Care and Education Programs

Child Care and Development Fund (CCDF) and State and Local Child Care Dollars

The Child Care and Development Fund (formerly the Child Care Development Block Grant—CCDBG) makes grants to states and tribal governments to assist low-income families in securing child care for children under age 13 (or up to age 19 at state discretion). The authorized activities include making direct subsidies for child care expenses, informing and empowering parents to make their own decisions, and assisting with the implementation of licensing standards and regulations. Discretionary funds may be set aside for quality expansion, strategies to improve the quality of infant and toddler child care, child care resource and referral activities, and after-school child care. Federal estimates suggest that overall about 12 percent of children eligible for subsidies receive them (although the proportions are higher in some jurisdictions).

Implications for Early Childhood Mental Health

The increasing time that young children, including infants and toddlers, are spending in child care settings has turned the spotlight on the need to develop early childhood mental health consultation and other strategies to help teachers promote healthy social and emotional relationships and manage classrooms with a significant number of young children whose behavior is challenging. Early childhood mental health strategies, particularly consultation to child care staff, are a "two-fer." They help young children directly, but they also help child care providers improve the quality of their classrooms and/or interactions with young children and their families.[7]

View from the Sites

Four of the six study sites have made the development of funding strategies for early childhood mental health consultation to child care centers, family day care homes, Head Start, Early Head Start, family resource support programs, shelters, and other settings where young children are found a central component of their initiatives. The catalysts have been a concern about school readiness as well as welfare reform. In two of the sites, child care funds have been key: in San Francisco, TANF funds were transferred for child care purposes (including support for the mental health consultation

program); in Vermont, state match dollars for the federal child care program are being used to support both consultation and special aides to help more troubled young children remain in their classrooms.

Head Start and Early Head Start

Head Start was created in 1965 to provide comprehensive educational, social, nutritional, health, and other services to low-income children ages three to five years. Early Head Start, created in 1993, is designed to provide funding for family-centered services to pregnant women, infants and toddlers, and their families to promote child development and family self-sufficiency. At least 90 percent of enrollees must come from families with incomes at or below the federal poverty level. No less than 10 percent of the total enrollment opportunities must be available to children with disabilities. Head Start programs are generally local, and any local government, tribal government, or public or private nonprofit agency may apply for a grant when the federal government requests solicitations. With some exceptions, Head Start grantees are required to provide 20 percent of the total cost of the program.

Implications for Early Childhood Mental Health

Head Start has long had a commitment to promoting mental health and emotional development as an integral part of a comprehensive child development program. Each Head Start program must have a mental health component. Current guidance calls for Head Start program sites to use the consultation services of a mental health professional.[8] However, implementing the mental health component has been difficult for local Head Start program sites. Long-standing challenges include reluctance to label children, skepticism about the effectiveness of mental health therapy, limited technical assistance, a limited pool of providers willing to take referrals, and inadequate resources to finance services and consultation.[9] Early Head Start has developed an Infant Mental Health Initiative to build on new knowledge about the importance of early development.

View from the Sites

In each case study, state officials reported that Head Start was a part of the early childhood care and education system and linked to efforts to promote emotional well-being. San Francisco has made a deliberate effort to reach Head Start centers with mental health consultation. However, no state or local area in this study is using Head Start as the primary vehicle for change.

HEAD START AND MENTAL HEALTH

Reports on the mental health component of the Head Start program* found that effective strategies typically:

- Integrate a mental health perspective.
- Focus on adults as well as children.
- Are strength-based and nonstigmatizing.
- Start where families are.
- Are clinically and culturally sensitive.
- Aim to improve program quality and support the culture of caring.
- Integrate mental health consultants as part of the program team.
- Are open to partnerships with parents and other providers.
- Link to other services for children with more serious emotional and behavioral disabilities.

* Yoshikawa, H. & Knitzer, J. (1997). *Lessons from the field: Head Start mental health strategies to meet changing needs.* New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health and American Orthopsychiatry Association.

Mental Health Programs

Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (SED)/Child Mental Health Services Initiative

The federal Children's Mental Health Services Initiative is administered by the Substance Abuse and Mental Health Services Administration. The purpose of this program is to provide multi-year funding to help communities develop community-based systems of care for children and adolescents with serious emotional disturbance along with their families. State, city/county, and tribal governments may apply for grant funds to develop services, including intensive day treatment, therapeutic foster care, intensive home-based services, and development of care plans. Federal dollars must be matched with state or local funds. SAMHSA also administers a number of grant programs related to the prevention or treatment of substance abuse and mental illness, sometimes calling for integrated attention to children as well as their parents.

Implications for Early Childhood Mental Health

There has been no special emphasis on serving young children through this program, although informal data suggest that a number of the more than 67 sites now funded are serving at least some young children. The federal guidelines, however, require a focus exclusively on children with serious emotional and behavioral disorders and do not permit services to children at risk for serious emotional and behavioral disorders. For young children, this has a particularly chilling effect on service delivery.

View from the Sites

Vermont is the only state in the country that has received funding to focus its children's mental health services grant on young children. One of the other sites mentioned linkages with an existing system of care effort to serve older children.

Programs for Young Children with Disabilities

Part C of IDEA: Early Intervention

Part C of the Individuals with Disabilities Education Act (IDEA) authorizes state Early Intervention programs for children ages birth to three years. Federal dollars pay for a portion of the program costs, with state awards based on the proportion of children aged birth to three in a state. Most, but not all states augment these federal funds with state appropriated dollars. Medicaid and private insurance pay for covered early intervention services. Some states' Early Intervention programs call for family cost-sharing through co-payments. No state is permitted to deny services to families who cannot pay. In every state, prior to the third birthday, children who have a developmental disability are entitled to services. The law also permits states to include infants and toddlers at risk for disabilities or delays. Only 11 states (California and Indiana in this study) have chosen this option.

Implications for Early Childhood Mental Health

In theory, Part C could be a very important resource for young infants and toddlers experiencing social and emotional problems and delays. States might also define eligibility in ways that include young children most at risk for developmental consequences from early exposure to factors such as documented parental substance abuse or clinical maternal depression, or exposure to significant domestic violence or abuse. In practice, however, infants and toddlers with or at risk for social-emotional delays and behavioral conditions are not as likely to be identified and receive services as children with cognitive, physical movement, or language delays.

Federal guidelines require a focus exclusively on children with serious emotional and behavioral disorders and do not permit services to children at risk for serious emotional and behavioral disorders. For young children, this has a particularly chilling effect on service delivery.

View from the Sites

In Indiana, the Part C program has been the center of the state's effort to address infant and toddler mental health issues. Florida and Indiana are both making efforts to train Part C early intervention providers and agencies to be more sensitive and skilled in working with young children experiencing relationship-related problems and disorders. In Vermont, at least one of the state's regions has integrated the CUPS program and the Part C program.

IDEA Part B: Preschool Special Education Program

Part B of IDEA authorizes state preschool special education programs for children ages three to five years. Federal support is blended with state general revenues, public and private insurance, and family out-of-pocket payments to finance the services. In every state, a child who has an identified disability is entitled to a free and appropriate public education. Identified disabilities include: mental retardation, hearing impairments, visual impairments, orthopedic impairments, autism, traumatic brain injury, developmental delays, emotional/behavioral disorders, or specific learning disabilities that require special education and related services.

Implications for Early Childhood Mental Health

Unlike the Part C early intervention program, the preschool special education program does not give states the option to serve young children at risk for social, emotional, and behavioral delays. Part B services are limited to children identified as having severe emotional and behavioral disorders.

View from the Sites

Case study interviews did not reveal any special efforts in Part B programs to promote the emotional well-being of young children or to link with the other identified initiatives. Some state agency and local program staff did report concerns that children with social, emotional, and behavioral problems who received services under Part C were not able to continue receiving services as preschoolers because of the more restrictive definitions. Others reported concerns about transitions to kindergarten. For instance, child care program directors who were able to maintain more troubled children in their classrooms through inclusion strategies raised concerns that, despite efforts to begin communication about the transition as much as a year in advance, schools are typically not prepared to serve young children with serious emotional and behavioral disorders.[10]

Temporary Assistance for Needy Families—TANF

Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), the TANF block grant program was created to replace the Aid to Families with Dependent Children entitlement program. Adoption of this policy changed the rules governing cash assistance and increased states' flexibility with regard to public assistance for low-income families with children. Under TANF, families receiving cash assistance and other benefits are subject to strict requirements, including a five-year limit on receiving public assistance, particularly cash benefits. At the same time, states have been given considerable flexibility in using TANF dollars to meet the legislated goals of the program, which are: to provide assistance to needy families with children in order to reduce dependency, promote work and marriage, reduce out-of-wedlock pregnancy, and encourage the formation and maintenance of two-parent families.

The flexibility of TANF to meet the broad purposes of the legislation offers states and communities an opportunity to use these dollars to promote healthy early social and emotional development for children affected by TANF processes.

Implications for Early Childhood Mental Health

There are two sets of implications. First, young children, particularly those at highest risk for social disadvantages and family crisis, are a core group affected by TANF changes. Children make up over two-thirds of all welfare recipients, with half of these being children under age six. The quality of child care is a huge challenge for this population, with many children in need of preventive and early intervention services. Research is also beginning to suggest that young children whose parents face the most significant barriers to employment (such as substance abuse, domestic violence, and depression, or who are threatened with or receive sanctions) may also experience higher rates of behavioral problems and poor cognitive development.[11] The second implication is that the flexibility of TANF to meet the broad purposes of the legislation offers states and communities an opportunity to use these dollars to promote healthy early social and emotional development for children affected by TANF processes.

View from the Sites

Only San Francisco reports using TANF dollars as a central funding tool for its early childhood mental health initiative, although other sites report blending TANF dollars.

Social Services Block Grant—SSBG

The Social Services Block Grant provides grants to states to carry out a wide array of social welfare programs and policies. These flexible funds may be spent on services, training, and administration. SSBG funds may only be used for services to families with incomes below 200 percent of the poverty line. Federal law permits transfer of up to 10 percent of a state's SSBG allocation to programs for preventive health services,

mental health services, alcohol and drug abuse services, and maternal and child health services. States may also transfer up to 10 percent of their TANF funds to the SSBG. Services delivered under the SSBG are not subject to the five-year federal life time limits of TANF. Furthermore, states may use SSBG dollars for noncash vouchers to families at risk for involvement in the child welfare/child protection systems due to sanctions or time limits.

Implications for Early Childhood Mental Health

SSBG funds may be used to support and augment early childhood mental health services. Federal funds may be used for activities that promote early childhood emotional well-being, such as child care services that meet state standards, parent education, or social services related to alcohol and drug rehabilitation.

View from the Sites

While no major new programs primarily supported by SSBG were reported, states are blending these dollars into pooled funds to enhance early childhood systems of care. For example, Indiana's finance system for First Steps Early Intervention uses a pool of combined state and federal dollars that includes funds from the SSBG.

State General Revenue Funds

Every state has discretion about how general revenue funds are used. For example, as of 2000, all but five states were investing in some kind of child development and family support programs for infants, toddlers, and preschoolers, as well as whatever investments they make in supplementing federal child care funds.[12] In many states, investments include home visiting programs. Most states have to augment federal IDEA Part C Early Intervention and Part B Preschool Special Education dollars just to meet their obligations under these entitlement programs. A few states are investing in state versions of Early Head Start. States also invest general revenue funds in child and adolescent mental health services, usually through their mental health departments.

Implications for Early Childhood Mental Health

There are two sets of implications. The first is that many of the early childhood programs in which states are investing could benefit from access to early childhood mental health services. The second is that states can use general revenue monies to match federal dollars being used to develop and pay for early childhood mental health services (and particularly to pay for those services that the federal funding streams cannot be used for) as well as to seed new initiatives.

View from the Sites

Most, but not all sites were thinking about how best to use state funds and how to match federal dollars strategically. In some sites, state officials have tried to use the state general revenue dollars for services, such as prevention, that are harder to fund under federal entitlements. In other sites, these discretionary dollars were being used to fund pilot projects. For example, in Vermont, state-appropriated funds for the CUPS match were designated for preventive services. Vermont has also used its state child care, mental health, and health monies as a strategic match for early childhood mental health services. In contrast, the state of Ohio used its state money to fund early childhood mental health programs without matching Medicaid or other federal dollars. In Florida, new state general revenues, without match, were dedicated to three pilot project sites. In addition, states can use general revenue funding to pay for services for which federal funding streams cannot be used.

Private Funds

States and communities also have access to private funds through foundations, United Way, and other philanthropic organizations. These, of course, vary considerably in size and in purpose. Nationally, foundation efforts have already played a role in promoting attention to early childhood mental health. For example, the Marguerite Casey Foundation, in partnership with SAMHSA, has provided substantial grants to promote early childhood mental health and emotional wellness programs across the country through the Starting Early Starting Smart Initiative.[13] The Ewing Marion Kauffman Foundation is working to build greater understanding of the relationship between early school success and social and emotional development.[14]

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Implications for Early Childhood Mental Health

Private money is an important catalyst in seeding pilot programs that can become models for public adoption and in providing money for services for which public funds cannot be easily used. Most importantly, private monies can be very critical in raising awareness about the importance of early childhood mental health.

View from the Sites

Private foundation grants were part of the initial or core funding in each of these case studies. The Carnegie Corporation of New York provided "Starting Points" grants designed to promote coordination, public engagement, and strategic planning for early childhood initiatives and thereby indirectly promoted attention to early childhood mental health issues in Vermont and San Francisco. The Peter and Miriam Haas Foundation supported early efforts to design and implement child care consultation services in San Francisco. The Mailman Foundation provided a grant to support early childhood mental health efforts in Florida. The Commonwealth Fund, through an early childhood development initiative, has provided dollars to Vermont for furthering a continuum of early childhood supports and maximizing Medicaid funding. Community foundations, United Way community organizations, and others have provided small grants that help launch or sustain training and service delivery efforts.

Lessons from the Sites

- Although there is no one categorical source of funding for early childhood mental health services, states and communities have a variety of funding streams to draw on in crafting funding strategies. These include entitlement dollars, state and local public funds, as well as private dollars and special grants.
- Major federal funding sources include Medicaid/EPSDT, the Child Care and Development Fund, TANF, the Children's Mental Health Services Program, and Part C, the Early Intervention Program of the IDEA.

SECTION 3: Financing Strategies

This section focuses on the strategies that the sites are using to develop and sustain early childhood mental health service initiatives. Building on the discussion of funding streams, it addresses three questions: What funding mechanisms are emerging to maximize fiscal resources? What planning and administrative mechanisms support efforts to finance early childhood mental health services? How are the sites addressing common barriers?

Funding Mechanisms to Maximize Fiscal Resources

To maximize existing funds, states and local areas are blending and "braiding" funds. The sites are also making specific efforts to maximize the impact of Medicaid funding, since that is potentially an important source of reimbursement.

Blending Funds

The term blended funds is used here to describe mechanisms that actually pool dollars from multiple sources and make them in some ways indistinguishable.

- The San Francisco mental health agency has developed a common billing process that it says works like "Pac-Man"—finding a path through the funding streams toward the payers of last resort. For example, in the case of mental health program consultation, the fees are primarily paid from the pooled fund of flexible dollars. Services that qualify for reimbursement from MediCal (the name for Medicaid in California) or Healthy Families (the name for SCHIP in California) are billed to those sources.
- The finance system for Indiana's initiative was redesigned by establishing the Central Reimbursement Office. This electronic system authorizes services based on each eligible child's Individualized Family Service Plan (IFSP), and providers are paid a uniform rate, being blinded to the source of payment. All reimbursements are settled using a "pay and chase" method—meaning that the state pays the

providers and then seeks reimbursement based on a funding hierarchy individualized to the eligible child. This new financing system depends on mechanisms that pool state and federal resources across program lines. Specifically, First Steps spending comes from a pool of combined state and federal dollars from state appropriations for early intervention services, federal Part C allocations, Title V MCH Services Block Grant Program for Children's Special Health Care Services, the Social Services Block Grant, Medicaid, and TANF. With a more integrated claims payment and data system, the most appropriate funding for each service can be used, and agency competition is being reduced.

Braiding Funds

In braiding, the funding streams remain visible but are used in common to give greater strength, efficiency, and/or effectiveness. In some states, funds are braided together to maximize multiple sources of state general revenues to match Medicaid federal dollars, depending on the nature of the service (e.g., child care, school-based, or home visiting).

- Vermont is an example of a state using a braiding strategy. The willingness of the Vermont Medicaid agency to share responsibility for managing specific aspects of the Medicaid program, combined with attention to opportunities for matching state with federal dollars, has greatly expanded the potential to meet the health needs of children. The Vermont Department of Mental Health Services manages those Medicaid services provided through the community mental health agencies and has been able to advance early childhood mental health financing through these centers. The Vermont Child Care Division also has maximized opportunities to match state funding with federal dollars for mental health services provided to children in child care settings. The Vermont Department of Health manages EPSDT and has been able to better blend funding for maternal and child health, children with special health care needs, and early intervention. Medicaid matching in the CUPS project also has been the result of cooperative arrangements.

MAXIMIZING THE IMPACT OF MEDICAID: LESSONS FROM THE SITES

To improve the applicability of Medicaid to early childhood mental health services, study sites have developed:

- Screening and assessment for emotional-behavioral concerns.
- Policies that clearly specify the range of early childhood mental health services covered.
- Policies that permit and/or encourage the use of mental health screening and assessment tools appropriate for young children, such as the recent classification system developed by Zero to Three, DC: 0–3.
- Policies that clarify the roles and responsibilities of mental health providers serving young children under EPSDT.
- Billing codes that can be used by providers of mental health services and supports for young children, their families, and their other caregivers.
- Centralized billing systems that blend or "pool" funds, thereby simplifying provider claims filing and maximizing use of available federal, state, and local funds.
- Appropriation of additional state funds to match with federal Medicaid dollars.
- Identifying previously untapped sources of state or local funds that can be used to match with federal Medicaid dollars.
- Approval for use of state child care, foster care, public health, maternal and child health, early intervention, mental health, and social services dollars as Medicaid matching funds in programs serving young children.

Maximizing the Impact of Medicaid

The Florida, Vermont, and Cuyahoga County, Ohio case studies highlight innovative policies and promising practices in Medicaid for funding early childhood mental health services for young children. In these cases, public officials and private organizations have worked together to devise mechanisms which maximize existing Medicaid coverage.

- Florida has made substantial changes to improve the structure of Medicaid in order to meet the emotional needs of young children. Through joint leadership of the Florida Medicaid and state mental health agencies, the state implemented a new mental health policy for children ages birth to five years in May 2002. The new policy recognizes that additional training is needed to serve very young children and their caregivers and includes changes to address the unmet needs of young children. Among other things, the new guidelines: (1) added a section clarifying

the "zero to five" coverage/assessment process and recommended use of the DC: 0–3 and other child-oriented diagnoses, although it still requires that diagnoses be linked with ICD 9 codes (International Classification of Diseases, 9th edition); (2) changed to permit billing for either individual or family therapy, which allows for relationship-based dyadic therapy; and (3) revised provider qualifications to permit a broader array of mental health service providers (i.e., nonphysician providers) to be reimbursed. Together these changes make it possible for young children enrolled in Medicaid to receive more appropriate assessment, diagnosis, and treatment.

- Vermont has made extensive use of opportunities to maximize the use of Medicaid. Vermont uses federal/state Medicaid dollars to finance a variety of services for young children with or at risk for mental health or behavioral health problems, including: early childhood mental health consultations, nurse home visits for at-risk families with young children, public health nurse case management for children entering the foster care system, and therapeutic play groups. These efforts reflect collaboration among Vermont's Department of Health that administers EPSDT, the Division of Mental Health that manages the majority of mental health spending under Medicaid, the Child Care Services Division of the Human Services Agency, and Medicaid. The Child Care Services Division's use of state child care funding matched to Medicaid in order to fund early childhood mental health and emotional wellness services is particularly innovative. Child care mental health consultation and individual aides for children with behavioral problems were initially financed by using state-only child care grant dollars. Now, the state is using and then blending state dollars to match Medicaid and other resources. Each of two community mental health centers received awards of approximately $40,000 for child care mental health consultation. These funds were used as a match to leverage Medicaid dollars, yielding more than $100,000 for each locality to provide mental health services to Medicaid beneficiaries in child care settings.

- Cuyahoga County (including Cleveland), Ohio has launched an Early Childhood Mental Health Pilot Project for the purpose of demonstrating improved outcomes with best practices and enhancing available resources. Three agency pilot projects are funded. One agency—the Positive Education Program—is using the pilot project as an opportunity to validate use of the DC: 0–3 diagnostic codes for Medicaid billing. It is also evaluating mechanisms to coordinate and integrate the Individual Service Plan required under state mental health rules and the IFS Plan required for children ages birth to three years served under the Part C program of IDEA in order to facilitate billing. Information from a successful pilot project could be used to restructure Medicaid financing for early childhood mental health services in Ohio.

"We need to better define what Medicaid and mental health dollars can and cannot finance... There are still a lot of red flags raised regarding services that appear to be social services or education."

Brett Jones, Finance Division, Ohio Department of Mental Health

- In San Francisco, the early childhood mental health consultation project sets out incentives for billing Medicaid and for making grant dollars stretch farther. If contractors bill Medicaid, their contract award is not reduced and they have more resources to spend on services not covered by Medicaid.

Using State Funds Strategically

Across the sites, state-appropriated mental health funds are being used to support pilot programs, match Medicaid funding, and finance nondirect program components such as staff and parent training.

- In Vermont, the Mental Health Agency was able to secure state-only dollars sufficient to match a federal grant and to focus on prevention. The state general fund "hard dollar" cash match for the CUPS program was approximately $1.5 million from mental health, $100,000 from child welfare, and $8,000 from education funding.

- Vermont adds state dollars intended to improve child care quality to the Child Care and Development Fund. The Vermont State Child Care Services Division allocates a portion of these child care quality dollars to child care mental health consultation and individual aides for children with behavioral problems. These activities were financed first using state-only grant dollars and now are financed from blended funds that include federal Medicaid match and other state and local resources. Leaders in the Vermont Child Care Services Division and the Department of Human Services in which it is located believe that quality child care should be able to meet the special needs of children with emotional and physical delays and conditions. The state legislature and Medicaid agency have supported this commitment.

"Medicaid has changed its community mental health services program policy to make terms, definitions, and coverage more relevant to young children, to take into account the symptoms and needs of young children... We are not just throwing money at a problem. The potential for prevention is well documented. The new strategy for 0-5 behavioral health assessment will become mandatory and, along with other Medicaid financing modifications, drive our system of care for young children toward prevention and early intervention."

Celeste Putnam, assistant secretary, Mental Health, Florida Department of Children and Families

Collaborative Planning and Administrative Mechanisms

Interagency and public-private collaboration are essential to developing a system of care that provides a continuum of services. Collaboration, once set in motion, works best where sustained by formal mechanisms. Financial arrangements frequently are supported by legislation, regulation, memoranda of understanding, and other formal guidance. For example, interagency agreements are being used to support and manage blended funding, overlapping eligibility categories, cross-system training, and care plan interfaces and transitions. Many of these elements are found across the sites.

- Indiana's new Part C financing system that blends state and federal funds depends on mechanisms that pool resources across program lines. Inter- and intra-agency collaborative partnerships (and the written memoranda of understanding which undergird these partnerships) were essential for coordinating resources for children ages birth to three years and in redesigning the Indiana financial system for early intervention. State financial planning has also linked closely with community planning initiatives.

- In Indiana, in addition to financing changes, the single-point-of-entry approach allowed for combined enrollment and created a single application form for Early Intervention, Medicaid/SCHIP (Hoosier Healthwise), Children with Special Health Care Needs, Women, Infants, and Children Nutrition Program (WIC), and other public health maternal and child health projects.

- Across the city of San Francisco, early childhood mental health consultation is supported by a range of federal, state, and local funds, including federal child care dollars, local general fund dollars, and the Children's Fund (Prop J, a city property tax set-aside). The San Francisco Children and Families Commission also dedicates a portion of the state revenues (from tobacco taxes) set aside in each county for investment in children ages birth to five years. Formal interagency agreements support these arrangements.

- Vermont used CUPS project funds for statewide expansion of key services such as: crisis outreach, intensive home-based services, respite care, intensive case management, individualized or wraparound services, and related training (including behavioral health consultation and mentoring). The intensive case management and wraparound services have been delivered in conjunction with a planned expansion of the Vermont Medicaid Waiver for children's services. Specialized rehabilitation for children in child care is happening in some regions, aided by collaboration with the Child Care Services Division of the state's child welfare agency.

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Strategic planning is underway at different levels. Indiana has focused their efforts through a single program plan that links other programs. Florida's private sector leaders have developed a statewide strategic plan with considerable involvement of the state government. Vermont state grants are used to promote community level planning. In Cuyahoga County, planning for early childhood mental health is a component of a broader planning and service development strategy.

- For more than a year, key stakeholders from across Florida participated in a strategic planning process focused on early childhood mental health. An advisory committee included representatives from key state agencies, universities, foundations, the judicial system, community-based providers, and private organizations concerned with the health and well being of young children. The project was based at the Florida State University Center for Prevention and Early Intervention Policy. The Florida Developmental Disabilities Council, Florida Department of Children and Families, and Ounce of Prevention of Florida played an instrumental role by supporting this planning effort. The resulting product—*Florida's Strategic Plan for Infant Mental Health*—is a blueprint for establishing a system of mental health services for young children and their families. The overarching goal of the plan is to develop a comprehensive system to effectively prevent, identify, and treat emotional and behavioral disorders in families with children birth to age five years.

- Through parallel state and regional planning processes, Vermont CUPS regional project staff have co-located or developed service linkages with parent-child centers, community mental health agencies, Part C early intervention programs, child care centers, visiting-nurse associations, and other local early childhood programs. CUPS activities are building the capacity of communities to fund, administer, and deliver behavioral health treatment for families with young children birth to age six years and behavioral health consultation for the early childhood care and education system.

- Through the Cuyahoga County Early Childhood Initiative, local public and private agencies are linking child care quality efforts, home visiting (Welcome Home and Early Start), health coverage outreach, and special needs child care. A central strategy is to use a "no wrong door" concept for service coordination. Local leaders recognized that much work needed to be done to build a system of care that could finance and deliver appropriate services to promote the emotional well-being of young children. Cuyahoga County launched an Early Childhood Mental Health Pilot Project to address these needs.

Perhaps the most common and repeated barrier reported by these sites (and by others as well) is the difficulty of providing preventive and early intervention services to children without requiring that they have a psychiatric diagnosis.

Common Challenges to Adequate Funding of Early Childhood Mental Health Services

These case studies highlight the impact of local and state leadership in addressing a major concern across the early childhood community: strengthening early childhood mental health services. But they also highlight three common barriers and dilemmas that these sites and other jurisdictions interested in moving forward will continue to encounter.

Funding for Early Intervention and Prevention

Perhaps the most common and repeated barrier reported by these sites (and by others as well) is the difficulty of providing preventive and early intervention services to children without requiring that they have a psychiatric diagnosis. Each of the sites has struggled and continues to struggle with this unfortunate reality. Program rules that link eligibility to diagnosis are a major barrier to promoting emotional development and preventive intervention. In every case study site, program managers identified problems in financing services to children and families without a specifically diagnosed mental health condition. In other words, it is most difficult to finance services to children at risk (i.e., early

ELIGIBILITY GUIDELINES FOR LEARNING GRANTS PROGRAM

Children eligible for social and emotional services to prevent early school failure under the Foundations for Learning Grants Program of the No Child Left Behind Education Act must have any two or more of the following risk factors:

- Abuse, maltreatment, or neglect.
- Homelessness, removed, or at risk for removal from child care, Head Start, or preschool for behavioral reasons.
- Exposure to parental depression or other mental illness or parental substance abuse.
- Identified early behavioral and peer relationship problems.
- Low birthweight.
- Family income below 200 percent of the poverty line.
- Cognitive deficit or developmental disability.

"Policies and programs aimed at improving the life chances of young children come in many varieties... They all share a belief that early childhood development is susceptible to environmental influences and that wise public investments in young children can increase the odds of favorable developmental outcomes."

National Research Council and Institute of Medicine, Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education; Shonkoff, J. P. & Phillips, D. (Eds.). (2001). *From neurons to neighborhoods: The science of early childhood development.* Washington, DC: National Academy Press., p. 10

intervention services) and services to support the healthy emotional development of young children (i.e., preventive services). State rules regarding Medicaid, SCHIP, Part C and Part B of IDEA, and Title V financing of mental health services are part of the problem, since federal rules would generally permit broader coverage.

The requirement that children have a diagnosis is unfortunate because it ignores a compelling body of scientific research both from developmental psychology and developmental psychopathology about the role of risk factors in the development of serious emotional and behavioral disorders, which, in young children, are especially predictive of later disorders.[15] Sites are trying to address this in two ways: first, by confronting the Medicaid barriers directly, and second, by mixing and matching funds to create a continuum of preventive, early intervention, and treatment services. It is also worth noting that the federal government has enacted the Foundations for Learning Grants program[16] that provides a model for how states might address the challenge of diagnosis and risk in still more innovative ways.

Using All Available Funds

A second challenge is how to maximize available funds across all potential funding sources. It is clear that only two of the sites have made a strategic effort to blend and braid funds across a wide range of programs, thereby creating the needed billing and monitoring changes. Yet all states and, in turn, local areas use funds from many sources. The challenge is twofold: to maximize available federal funds from the range of programs (including Medicaid, IDEA, Title V, child care, Head Start, and other federal grants) and to be strategic about the state match. The payoff, as the Indiana and Vermont experiences show, is likely to involve increased collaboration, more efficient use of public dollars, and an improved array of services and training for young children, their families, and their other caregivers, as well as mental health and other professionals.

Sustaining Funding

A third challenge that is a constant theme in the case studies is a concern that turning short-term grant dollars into statewide, sustainable efforts is difficult in tight budget times. Pilot and demonstration projects can help validate tools and test model approaches, but sustaining the activities beyond the pilot phase requires renewed efforts to secure funds. Across each of the sites, state and local agencies face these challenges, which are compounded by state budget shortfalls and budget cuts.

SECTION 4:
Key Findings and Recommendations

Taken together, these case studies offer important lessons to other jurisdictions seeking to invest in strategies to promote healthy social, emotional, and behavioral development in young children, particularly those whose development is threatened by poverty or other risk factors. Across the sites:

1. *Early childhood mental health initiatives build on and are linked with larger efforts to promote positive outcomes in young children.* Broad early childhood initiatives provide a platform on which to build, laying the ground work for further development of collaboration, pooled funding, and preventive investments related to early childhood mental health. In each of the case study sites, both collaboration and creative thinking and planning about early childhood were underway, frequently with high-level gubernatorial support. This made it easier to craft initiatives that aimed to infuse early childhood mental health principles and practices into settings where young children are found.

2. *There is no single right approach to funding early childhood mental health supports and services.* Each state or community studied started with a different program approach, population, or funding stream. In many instances, the efforts evolved and grew over time, taking on a clearer focus and vision. In others, the efforts are more limited and fragmented but still provide a foundation for future development.

3. *Collaboration across agencies has been key to developing more comprehensive funding strategies, with both mental health and child care agencies playing a key role in most, but not all, sites.* Across all the sites, state and county mental health agencies are actively engaging in efforts to promote early childhood mental health services. Similarly, focusing on child care quality and access for children facing special challenges, a number of child care agencies have committed resources to support the emotional development of young children. Both San Francisco and Vermont allocate a portion of their quality child care dollars for mental health consultation. In Indiana, the catalyst was a desire to improve the state's early intervention program, again by engaging a broad group of stakeholders, including many agency administrators.

4. *State Medicaid agencies have developed new policies to address early childhood program needs, but are not financing many of the covered services that children need to prevent or ameliorate early social, emotional, and behavioral problems.* No case study site has fully maximized Medicaid to fund a variety of mental health services. Florida has revised its policy guidance to provide more appropriate assessment and treatment for young children, while Vermont is using Medicaid to fund a variety of mental health services. But even in these states, Medicaid's EPSDT policies have not been used to their full legal potential. One site, San Francisco, has built in local incentives for maximizing the use of Medicaid at the local level.

5. *Other federal programs have played supporting roles in some but not all of the sites.* For example, Part C has been central in Indiana, TANF in San Francisco. No state has pooled monies across all the potentially applicable funding streams, although Vermont and Indiana are both trying to do this more systematically.

6. *Some, but not all of the sites have been using state general revenues or federal match monies strategically.* For those sites that do use this approach, the San Francisco and the Indiana experience suggest the importance of reviewing billing processes to streamline the burden at the local level.

7. *There is more flexibility in federal programs and other funding streams than has been effectively used.* These case studies illustrate how states could better use key financing opportunities, particularly federal funding streams. Federally defined entitlement programs are the most reliable and sustained sources of funding and are important because they can follow an individual child according to need. Beyond these entitlement programs, federal and state funding for mental health, children with special health care needs, substance abuse interventions, and early child care and education are used to pay for smaller

efforts but rarely to finance early childhood mental health services in a systematic fashion.

8. *External resources can serve as a stimulus for an enhanced programmatic effort.* In most cases, grant dollars or special funds—both public and private—were instrumental in launching new efforts. In Indiana and Vermont, federal grants through Title V and Children's Mental Health grants were the fiscal catalysts. In San Francisco, the flexibility of TANF provided the financial lever. But in each instance, the dollars were not explicitly designed to promote early childhood mental health. It took state and local leaders to put together the vision, application, and implementation effort.

9. *A broad array of early childhood mental health services are being funded, although not necessarily within all the sites.* Despite the difficulty of providing preventive and early intervention services, many of the sites are concentrating on funding just these kinds of services, particularly early childhood mental health consultation, training, and support groups for those who work directly with the children and families. A few sites are focusing on screening and assessment strategies, trying to build the knowledge base of what can be reimbursed. A few sites, Florida and Vermont, for instance, are also addressing the needs of the most troubled young children.

10. *Exercising leadership does not depend upon where you work but how you work.* Leadership comes in many forms at many levels. In every site, leadership was a key element of success. An individual hired to administer a short term federal grant project can provide the leadership for broad systems change; one early intervention or child care program director can hold up a vision for change that others will help implement; one legislator champion can provide the momentum for substantially increased financing; and one provider/advocate can set out to fix a problem and end up creating a new initiative.

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Ten Action Steps for States and Communities

Building on the lessons of these pioneering sites, below are action steps that other communities and states can take to strengthen their attention to the social, emotional, and behavioral needs of young children.

1. Start small. Apply for small grants or turn to local foundations to jump-start a community- or state-level planning process, building on other collaborations on behalf of young children.

2. Test out new service approaches to make sure they fit with the community. Consider evidence-based practice, where there is an evidence base, and lessons from prior efforts.

3. Develop cross-training initiatives to build a shared understanding of what early childhood mental health services are and why they should be funded.

4. Build or strengthen collaborative relationships to develop a systematic funding strategy to permit the development of preventive and early intervention services. For example, use child care improvement funds for mental health consultation; establish or use existing formal mechanisms at the cabinet, state agency, or local agency level; make sure parents are involved.

5. Analyze existing levels of funding for early childhood mental health. Are funds being used for the right services, including early intervention? Are the funds sufficient? Do services address the needs of infants and toddlers as well as preschoolers?

6. Assess the funding streams that could be used and what barriers they pose. For example, does the state Medicaid plan pay for child and family therapy? Must the language be changed?

7. Develop a targeted strategy to maximize the impact of Medicaid/EPSDT. For example, include age-appropriate developmental, emotional, and behavioral measures into the recommended EPSDT screening protocol; make sure that reimbursed services are appropriately defined for young children; make sure that parent-child therapies are covered.

8. Consider redesigning reimbursement and billing practices to maximize the use of all available dollars, exploring some of the strategies used by the sites described in this report.

9. Develop a strategy to gather the kind of outcome data needed to refine and sustain funding for early childhood mental health strategies.

10. Promote the development of targeted federal funding as a catalyst for the development of early childhood mental health services. One way would be to encourage the Center on Medicare and Medicaid Services, formerly the Health Care Financing Administration, to provide technical assistance to states through groups, conferences, and other methods to help them fund early childhood mental health services.

"Early childhood mental health is a problem. Families don't know how to get what they need. We seem to have nowhere to refer families with kids who have mental health problems.... The system is difficult. Parents are in a terrible circle of frustration rather than a circle of support. If a child is in a wheelchair, there is not a question about what to do or when to diagnose a condition."

Connie Wells, Florida Institute for Family Involvement

APPENDIX A

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APPENDIX B

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The NATIONAL CENTER FOR CHILDREN IN POVERTY (NCCP) was established in 1989 at the School of Public Health, Columbia University, with core support from the Ford Foundation and the Carnegie Corporation of New York. The Center's mission is to identify and promote strategies that prevent child poverty in the United States and that improve the lives of low-income children and their families.

NCCP:

- Places a special emphasis on preventing or alleviating poverty among children under age six because young child poverty poses particularly serious risks to children's healthy growth and development.
- Conducts and synthesizes relevant research to meet the needs of key audiences that work on issues affecting low-income families.
- Uses sound research to identify and promote wise investments in low-income families that have important long-term benefits for children, families, their communities, their states, and the nation as a whole.
- Employs a multi-disciplinary approach to build bridges between academic research, field-based knowledge of the experiences of low-income families raising children, attitudinal research, and the development of public and private sector initiatives for low-income families with children.
- Works to accurately, effectively, clearly, and broadly communicate its research in compelling ways.
- Emphasizes providing useful information to state and local policymakers as they establish goals and objectives and allocate resources for efforts to prevent or alleviate child poverty.
- Helps key stakeholders and the general public understand and effectively respond to the constantly changing face of child poverty. NCCP does this by assessing and tracking: the definition and measurement of child poverty; the impact of child poverty on various sub-populations; the effects of particular policies on low-income families and children; and public attitudes and awareness regarding child poverty, low-income families, and related issues.

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